



# Welcome to your U.S. health benefits.

Fincantieri Marine Group, LLC





# What to expect when you need care.

Welcome to your assignment in the United States. Your UnitedHealthcare Global Insurance plan is designed to get you the health care resources you need, efficiently and simply, during your stay.

The health care system in the United States may be very different from the health care system in your home country. This guide is designed to make your transition easier. Facts and tips are divided into sections that walk you through everything you need to know. We suggest you read through the guide once, and then save it for future reference.

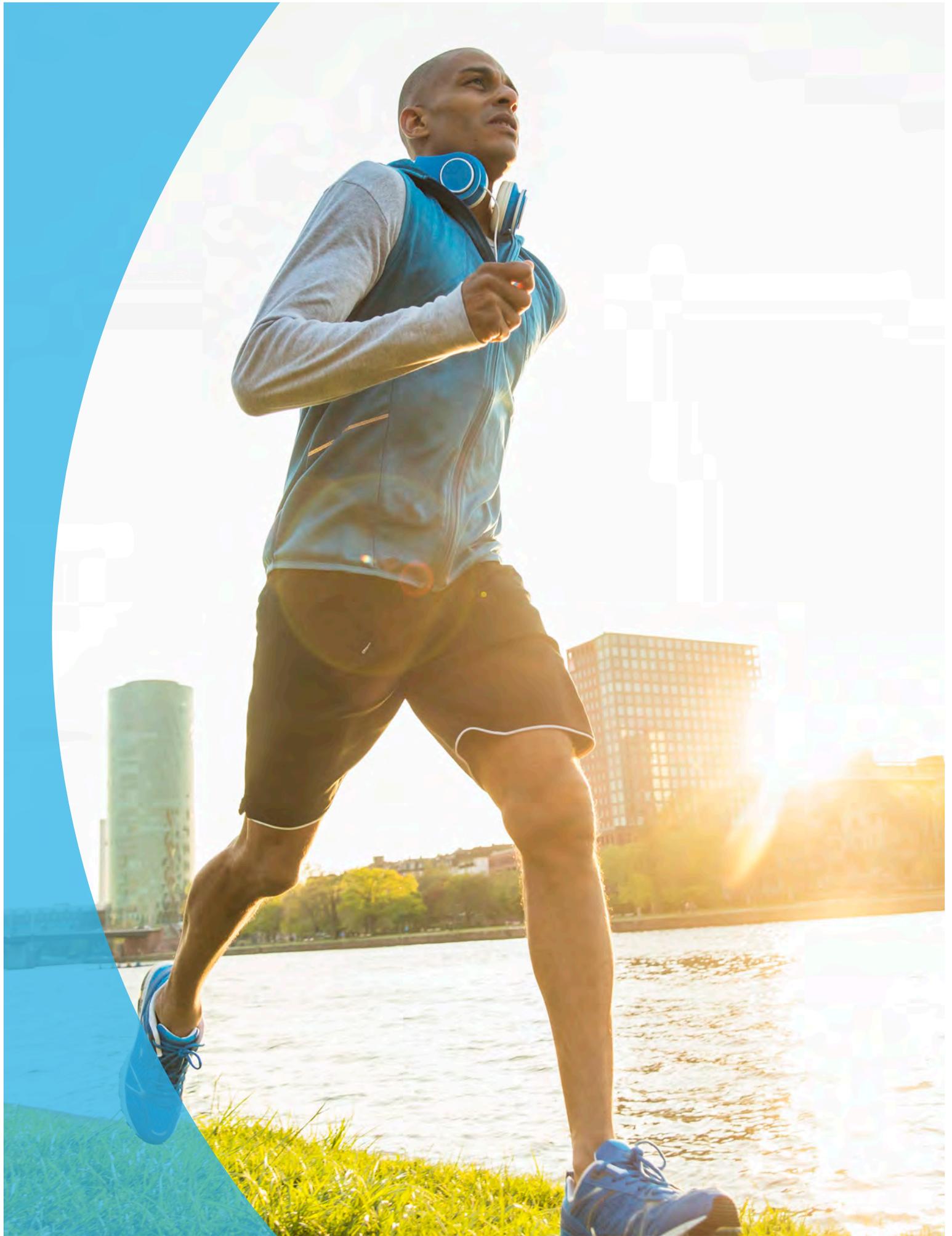
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## Call us. We're here to help.

 **+1.877.844.0280** or **+1.763.274.7362**

- Call **Customer Care to** talk with a trained specialist any time, night or day, any day of the year.
- **Multilingual representatives and interpreters are available**, so you can talk with us in the language of your choice.
- We can help you find a health care provider who speaks your preferred language, help you get care, and support you if you are already in the course of receiving care.



# 1 Get Started

## Your expatriate journey

### Helping you navigate



Adjusting to life as an expatriate and accessing health care while on assignment can be more challenging than at home. UnitedHealthcare Global is providing this welcome information and additional resources to make sure you have the support you need, every step of the journey. We'll help you navigate the health system in your host country and overcome language or cultural barriers. We're also here to help your covered family members, who may not have made the journey with you.

#### New expatriate journey

#### Existing expatriate journey

**Welcome Call:** Your journey begins with a Welcome call. Your Customer Care team invites you to schedule or request a personalized overview of your health benefits, the resources available to you, and all of the ways we can help.

**Assignment Readiness:** We will provide pre-deployment planning and clinical support to identify any specific needs you may have.

**Continuity of Care:** If you are already on assignment, we're here to consult with you and your family to help make sure you can continue to receive appropriate care for any conditions or treatment plan.

**Your ID Card:** You will receive an ID card, which provides doctors' offices and hospitals with important information regarding your coverage. Take your ID card with you to your health care appointment.

**The U.S. Network:** We'll help you find doctors, hospitals and retail pharmacies to get the care you and your family needs, anywhere you are.

**Customer Care:** We're here for you 24/7/365 by phone or through our self-service tools.

**Technology Tools:** A range of mobile and desktop tools provides you with options for managing your health.

**Health Management and Wellness:** Members with health conditions or requiring additional support can connect with a clinician or a professional counselor.

**Re-integration support:** After successfully completing your assignment, we're here to help transition to life and work in your home country.

# Common terms

## Frequently used words in the U.S. health care system



### **Claim**

A request for payment that a member or health care provider submits to a health insurer when the member receives covered health care services.

### **Coinsurance**

The percentage of costs of a covered health care service a member pays after the deductible has been paid.

### **Copayment**

A fixed amount a member pays for a covered health care service after the deductible has been paid. “Copay” is another way of saying “copayment.”

### **Date of service**

The date health care services took place.

### **Deductible**

The amount a member pays for covered health care services before the insurance plan starts to pay. After a member pays the deductible, usually the member is only responsible for copayment or coinsurance for covered services.

### **Dependent**

A person who relies on an enrollee for financial support and/or receives health coverage through a spouse or a parent who is the enrollee.

### **Eligibility date**

The date a covered person becomes eligible for benefits under an existing health insurance policy.

### **Enrollee**

A person who is enrolled for coverage under a health insurance policy and who is eligible on his or her own behalf (not by virtue of being an eligible dependent) to receive health services under the health insurance policy. Also known as a subscriber.

### **Exclusions**

Specific conditions or circumstances listed in the health insurance policy for which the policy does not offer reimbursement.

**Explanation of Benefits (EOB)**

The insurance company’s written explanation regarding a claim, showing what they paid and what the patient must pay.

**Facility**

The physical location where health care services are provided, such as a hospital, clinic, emergency room or ambulatory care center.

**Member**

A person who has been enrolled in a health insurance policy during the reporting period. Members include all people directly enrolled and their eligible dependents. This is also known as covered person and plan participant.

**Network**

A system of contracted physicians, hospitals and other providers who deliver health care to members. In-network care only applies to providers in the U.S. To find network providers in the U.S., use myuhc.com or call the telephone number on your member ID card.

**Out-of-network**

Out-of-network, or non-network, refers to U.S. physicians, hospitals or other health care providers who do not participate with UnitedHealthcare as contracted providers. Out-of-network providers have not agreed to accept negotiated prices. If you choose care from an out-of-network provider, health care expenses that you are responsible for paying will likely be higher. In-network and out-of-network care only applies to providers in the U.S.

**Prior authorization**

Approval from a health insurer that may be required before receiving health care services or filling a prescription in order for the service or prescription to be covered by the health insurance policy.

**Provider**

A physician, hospital, group practice, nursing home, pharmacy, or any individual or group of individuals who provide a health care service.

**Need a different definition?**

**Customer Care** can help explain unfamiliar words that are not included here.

 **+1.877.844.0280** or **+1.763.274.7362**

## Get Started



# Your medical ID card, one website, one number to call

## Review your medical ID card



## Always keep your ID card with you.

Your ID cards contains a lot of information about your benefits, so it's important to know what everything means.

- 1. Member ID:** Identifies you as a covered individual and is how we keep track of your benefit usage. When you call Customer Care, you will be asked for this number.
- 2. Group number:** Identifies your employer and the plan you are in.
- 3. Member:** The name of the person who carries the plan.
- 4. Dependents:** Names of everyone covered under the plan.
- 5. Office:** Amount you owe at a primary care physician visit.
- 6. ER:** Amount you owe at an emergency room visit.
- 7. UrgCare:** Amount you owe at a visit to an urgent care center.
- 8. Spec:** Amount you owe at a specialist visit.
- 9. Rx Bin & Rx Grp:** Identifies you as a UnitedHealthcare member for OptumRx prescription drug administration in the U.S.
- 10. www.myuhc.com:** Your member website, where you can manage your benefits.
- 11. +1.877.844.0280:** 24/7 Customer Care number to call



Health Plan

## Expatriate Insurance

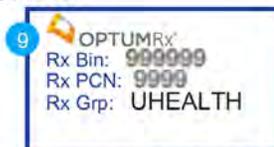
**1** Member ID: **123456789** **2** Group Number: **999999**

**3** Member:  
SUBSCRIBER SMITH

**4** Dependents:  
SPOUSE SMITH  
CHILD1 SMITH  
CHILD2 SMITH  
CHILD3 SMITH

Payer ID 99999

**5** U.S. Copays:  
Office: \$25 **6** ER: \$250  
**7** UrgCare: \$10 **8** Spec: \$35



0501

UnitedHealthcare Expat InsuranceChoice Plus  
Administered by United Healthcare Services, Inc.

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.

For Members: **10** myuhc.com **11** +1.877.844.0280  
Calls Outside U.S.: +1.763.274.7362

For U.S. Providers: www.UnitedHealthcareOnline.com 877-842-3210  
For Non-U.S. Providers: +1 763-274-7362  
International Claim Fax: +1 813-877-8167  
Medical Claims: PO Box 740111, Atlanta, GA 30374-0111

Pharmacy Claims: PO Box 740111, Atlanta, GA 30374-0111  
For U.S. Pharmacists: 888-290-5416

## Register at myuhc.com



### It's your direct connection, day and night.

Use your secure web portal to find information and tools to help you get the most out of your benefits.

- See what's covered
- Find a network doctor, clinic or hospital
- Submit and track claims
- Translate medical and pharmacy terms
- Get a replacement for your member ID card
- And much, much more

### Registration is easy.

Registering at **myuhc.com** will give you one universal login – your **HealthSafe ID** – that you can use on **myuhc.com**, or on the **Health4Me® smartphone app**.

Have your ID card ready (or you can use your Social Security Number if you have one and date of birth) and then:

- 1 Go to [www.myuhc.com](http://www.myuhc.com)
- 2 Select Register Now
- 3 Follow the step-by-step instructions - you will be guided along the way with helpful onscreen feedback. Remember to sign up for paperless communications, which allow us to communicate important updates to you via email.

If you have previously registered for myuhc.com as a UnitedHealthcare member, you will need to register again for access to your UnitedHealthcare Global benefits and information.

### One password is all you need.

Register at **myuhc.com**, and use the same Health-Safe ID username and password to log in to:

- myuhc.com health benefits portal
- Health4Me mobile application

## Get Started



## Download the Health4Me™ mobile app

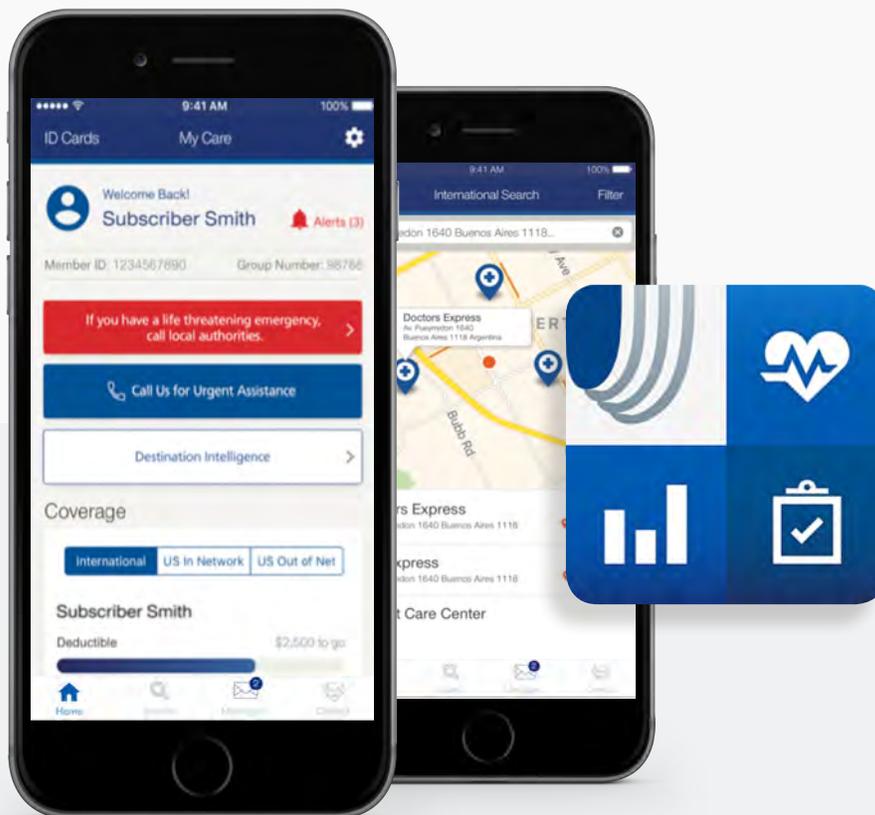


## You can do so much with Health4Me

With mobile functionality designed especially for expatriates, the award-winning Health4Me app travels with you, wherever you are. You can download it from the App Store® or Google Play™ in the U.S., Singapore, and the United Arab Emirates. Once downloaded, it works around the world.

Use the same credentials you use to log in to **myuhc.com**. Then:

- **Find a doctor, hospital or clinic nearby**
- **Identify providers who accept direct payments from UnitedHealthcare Global**
- **View recent medical and security alerts globally or by country**
- **Subscribe to receive future medical and security alerts for up to 10 countries, including your current GPS location of the mobile device**
- **Call us for urgent help with one touch**
- **Review your coverage**
- **Upload and track claims**
- **Share your ID card with your doctor**

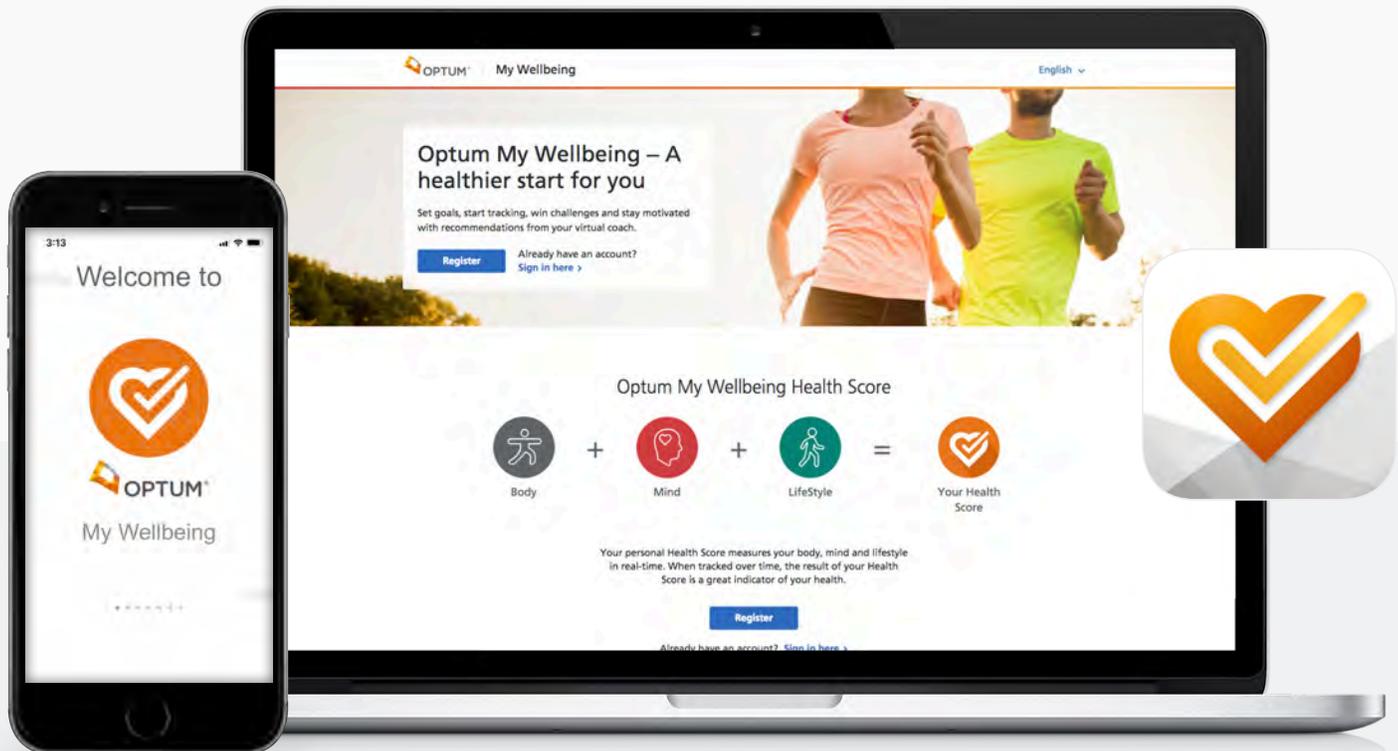
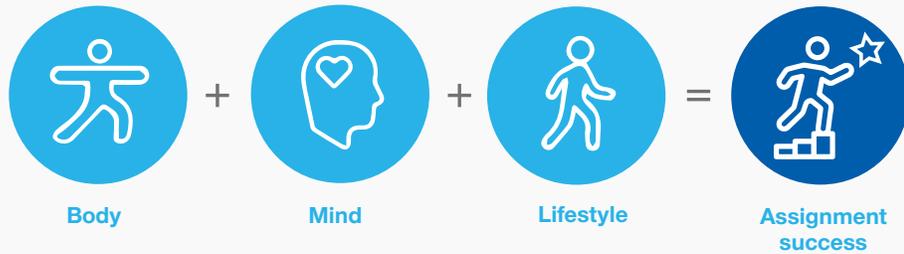


# My Wellbeing



## For a healthier journey

My Wellbeing is a digital health platform provided by Optum®, a UnitedHealth Group® company, designed to help you and your dependents create and sustain positive behavioral changes and inspire the development of healthy habits for life.



## Get Started



## My Wellbeing (cont.)



### Personalized Goals and Challenges

- Set personal goals
- Join online group activity challenges
- Choose from social, physical or nutrition programs

### Real-time Health and Activity Tracking

- Discover your Health Score and use it to track your results to achieve your goals
- Get support from a virtual coach

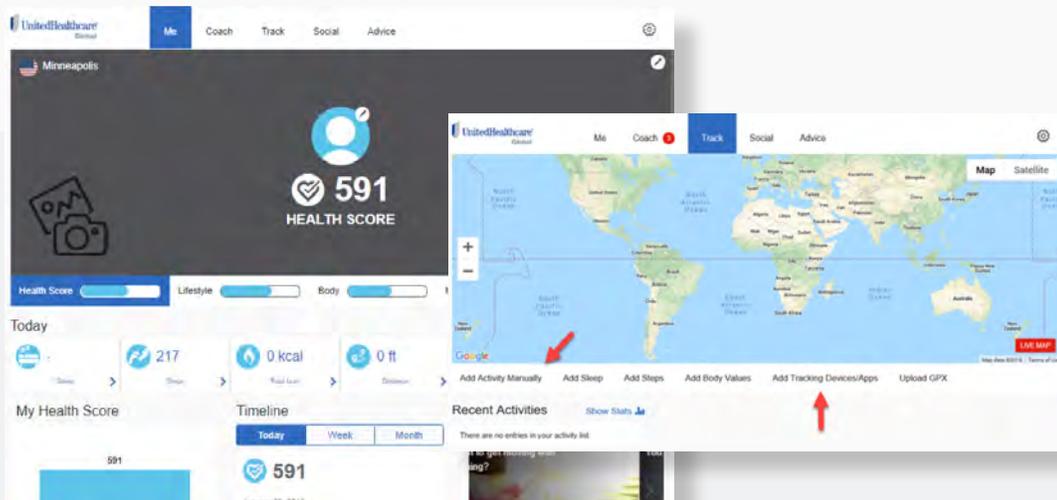
### Stay Connected, Stay Focused

- Get inspired and focused with online communities
- Receive timely coach check-ins and reminders can help you set goals and stay inspired
- Support available in 12 languages

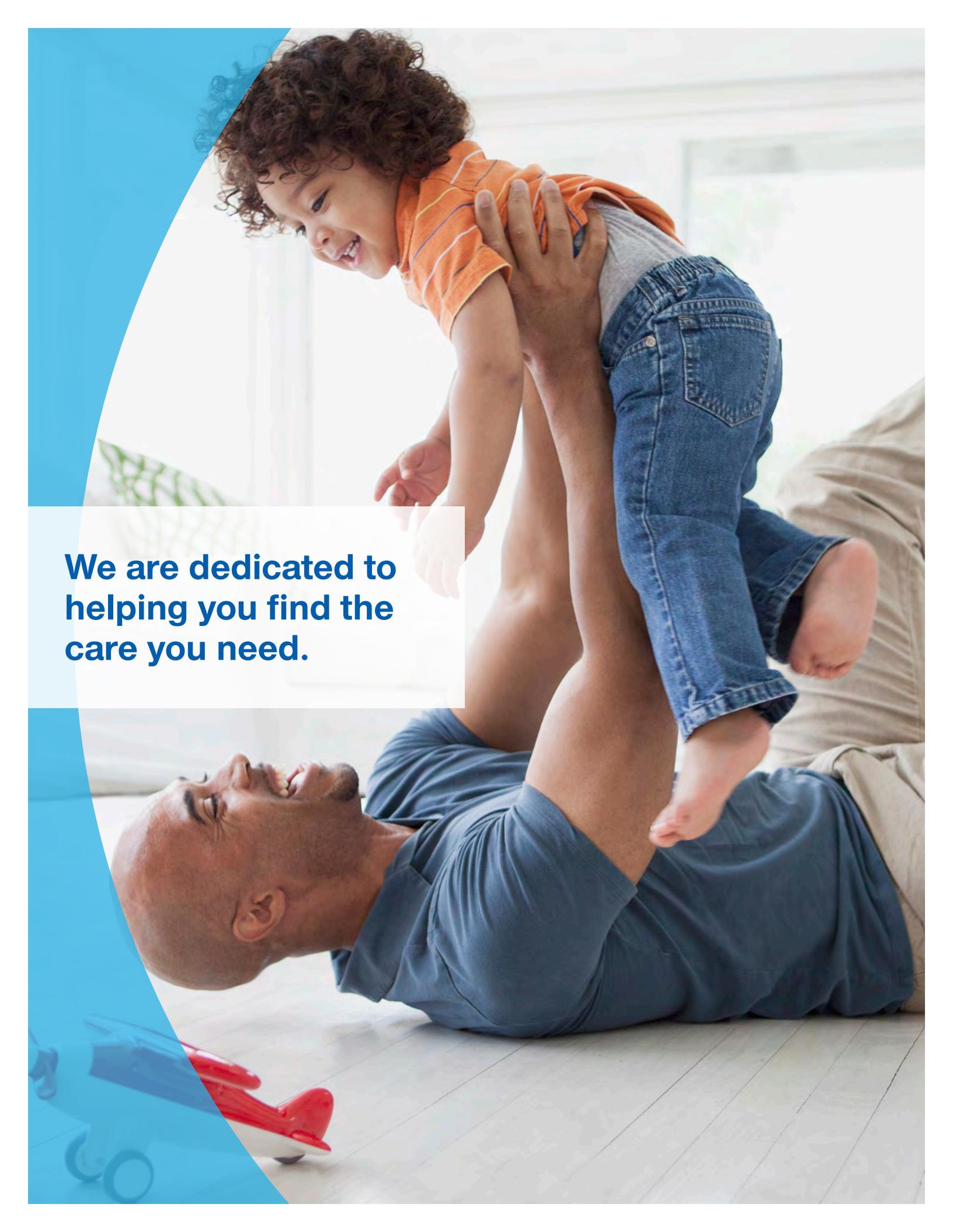
### Seamlessly Connected

- Easily accessed by smartphone or online
- Connects to health-related devices and apps, such as heartrate and blood pressure trackers

Available at [mywellbeingsolution.com](http://mywellbeingsolution.com). Enter Company Access Code **uhcglobal**. Download the Optum My Wellbeing app from your favorite app store.





A photograph of a man with a shaved head, wearing a blue t-shirt, lying on his back on a light-colored wooden floor. He is smiling and looking up at a young child with curly hair who is being held up in the air by the man's hands. The child is wearing an orange and white striped shirt and blue jeans. The background shows a window with blinds and a beige sofa. A red toy airplane is visible on the floor in the bottom left corner. The image is framed by a blue curved shape on the left side.

**We are dedicated to helping you find the care you need.**

## 2 Find Care

# Quality care, options for treatment

### When you need care



It isn't always easy to find a doctor who is right for you. Using our online tools and information can help you make more confident decisions. In this section, you will find information about how to find care when you need it, as well as the types of care centers available to you.

### Things to remember

- **When you get care from doctors who are in the network**, cost sharing and out-of-pocket expenses are usually lower. Emergency health services are paid as in-network benefits.
- **When you get care from providers who are out of the network**, cost sharing and out-of-pocket expenses are usually higher.
- **Always carry your UnitedHealthcare Global member ID card with you.** During your health care appointment, present your member ID card so that the office staff can call UnitedHealthcare Global to confirm your benefits.

### Is it an emergency?

**Visit an emergency room or call 911**, which is the telephone number used to call for emergency medical assistance wherever you are in the U.S.

# Where to go for care

## Find a doctor



Your plan gives you access to a network of more than one million doctors, hospitals, clinics and labs in the United States. To find a provider in your location:

- Visit **myuhc.com** and select **Find a Doctor**, OR
- Call **Customer Care: toll-free +1.877.844.0280** or **+1.763.274.7362**

Multilingual Customer Care representatives and interpreter services are available, so you can speak in the language of your choice. We can help you find a health care provider who speaks your preferred language and guide you through the U.S. health care system.

## Choosing a primary doctor

Use **myuhc.com** to find network doctors nearby and to review basic information about them. It's a good idea to collect the following information about the doctor you choose and keep it on hand at home.

### Office contact information

Phone and fax numbers, office hours, web address, e-mail policy, hours of operation and office location.

### Appointments

Hours to call, what happens if you miss an appointment, and whether or not they give estimates of waiting times.

## Cost-saving tip:

### Use **myuhc.com** to find a doctor in your network.

These doctors have agreed to charge lower prices without diminishing quality of service. If the doctor is not in our network, you may have to pay at the time of service.

### Documents

The documents you will need to bring to your appointment, such as a health plan ID card or personal identification.

### Prior authorization

Whether you need pre-authorization before seeing this doctor, and the steps you must take to obtain pre-authorization.

### Special needs

Whether any special needs, such as physical navigation, hearing or visual impairments or translation, can be accommodated.

### Prescriptions

How to get refills, report side effects or change treatment plans.

## Make the most of your doctor visits

**When you visit, show your member ID** card so they know how to bill for their services. During a visit, your primary doctor will:

- Check your health history, family history and medical records
- Deliver preventive and routine care
- Manage your medications
- Refer you to a specialist if you need one

## If you are admitted to a hospital

There may come a time when you need to be admitted to a hospital. There are two major types of hospital admission:

**Emergent** – Usually happens when a patient is seen in the emergency room and is then admitted to the hospital.

**Elective** – Occurs when a doctor requests that a bed be reserved for a patient on a specific day. The patient checks in at the admissions office and is taken to an assigned room.

### Bring these items when you are admitted

- **Your UnitedHealthcare Global member ID card**
- **Personal identification**
- **Emergency contact information** (relatives' or friends' names and phone numbers)

## Find Care



- **List of all drug allergies**, including a description of the reaction
- **List of all current medications**, including prescription, over-the-counter, herbal remedies and energy enhancers (or, put them all in a bag and bring them with you)
- **List of medical conditions**
- **List of all prior surgeries**, including minor and elective
- **The names of your primary doctor and any specialists you see**

## Planning for discharge

Your UnitedHealthcare Global case manager can work with your doctor, nurse and you to determine how long you will stay in the hospital. When it's time for discharge, make sure you have answers to these questions.

### Home care

Will you need home nursing care or other arrangements?

### Therapy

Where will you go to receive rehabilitation?

### Medication

- What new medication will you need to take and for how long?
- Are there side effects or interactions with your other medications?
- Does your insurance cover it, do you need prior authorization, and how much will it cost?
- If it's too expensive for you, are there alternatives?

### Back to work

- When can you resume your regular activities or return to work?
- Are there limits to what you can do at work or home? (Your doctor should provide a note for your employer regarding any restrictions.)

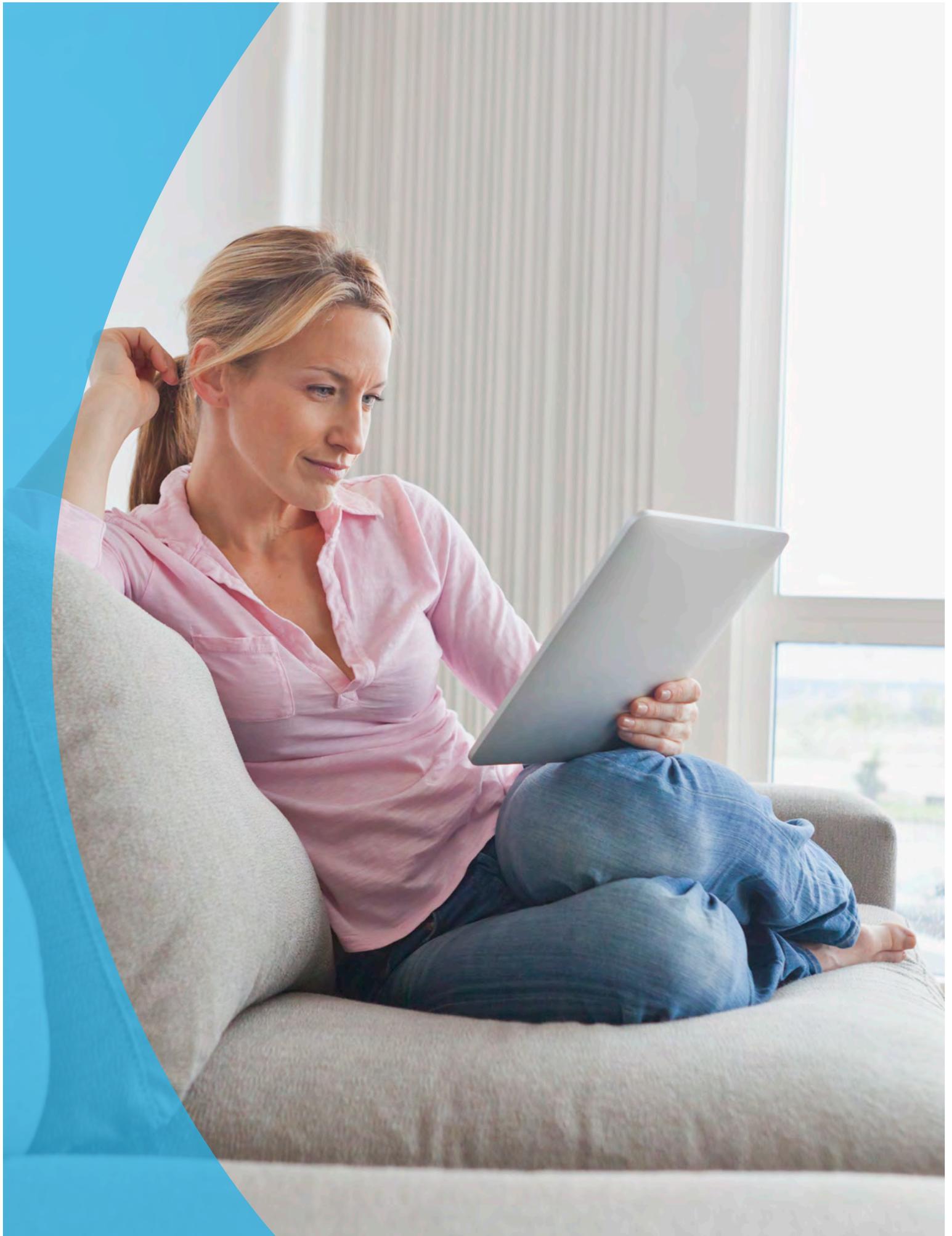
### Follow-up

- Which health care provider do you follow up with and when?
- If you are responsible for scheduling your own follow-up, who do you call?
- What phone numbers do you need?
- On what date is your follow-up visit scheduled?
- Where do you go for the follow-up visit?



In the United States, you have several options for where to get care. Most people choose a primary care doctor to be their regular physician, and with whom they can form a doctor-patient relationship. But there are other options for treatment, depending on the situation. This chart describes the options.

<b>Doctor's office</b>	<b>You need routine care for a current health issue.</b> Your primary doctor knows you and your health history, and can access your medical records, provide preventive and routine care, manage your medications, and refer you to a specialist if needed.	<ul style="list-style-type: none"> <li>• Routine checkups</li> <li>• Immunizations</li> <li>• Preventive services</li> <li>• Manage your general health</li> </ul>	<ul style="list-style-type: none"> <li>• Often requires a copayment and/or coinsurance. See your benefit summary for costs that apply.</li> <li>• Normally requires an appointment</li> <li>• Little wait time with a scheduled appointment</li> </ul>
<b>Convenience care clinic</b>	<b>You can't get to your doctor's office, but your condition isn't urgent or an emergency.</b> These clinics are often located in shopping malls, pharmacies or retail stores offering services for minor health conditions. Staffed by nurse practitioners and physician assistants.	<ul style="list-style-type: none"> <li>• Common infections (like strep throat)</li> <li>• Minor skin conditions (like poison ivy)</li> <li>• Flu shots</li> <li>• Pregnancy tests</li> <li>• Minor cuts</li> <li>• Earaches</li> </ul>	<ul style="list-style-type: none"> <li>• Often requires a copayment and/or coinsurance similar to an office visit. See your benefit summary for costs that apply.</li> <li>• Walk-in patients are welcome with no appointment. Wait times can vary.</li> </ul>
<b>Urgent care center</b>	<b>You may need care quickly, but it's not an emergency and your primary doctor may not be available.</b> These centers offer treatment for non-life-threatening injuries or illnesses. Staffed by qualified doctors.	<ul style="list-style-type: none"> <li>• Sprains</li> <li>• Strains</li> <li>• Minor broken bones (like a finger)</li> <li>• Minor infections</li> <li>• Minor burns</li> </ul>	<ul style="list-style-type: none"> <li>• Often requires a copayment and/or coinsurance, usually higher than an office visit. See your benefit summary for costs that apply.</li> <li>• Walk-in patients are welcome. Waiting periods may be longer since patients with more urgent needs are seen first.</li> </ul>
<b>Emergency room</b>	<b>You need immediate treatment of a very serious or life-threatening condition.</b> Do not ignore an emergency. If a situation seems life-threatening, call 911 or your local emergency number right away.	<ul style="list-style-type: none"> <li>• Heavy bleeding</li> <li>• Large open wounds</li> <li>• Sudden change in vision</li> <li>• Chest pain</li> <li>• Sudden weakness or trouble talking</li> <li>• Major burns</li> <li>• Spinal injury</li> <li>• Severe head injury</li> <li>• Difficulty breathing</li> <li>• Major broken bones</li> </ul>	<ul style="list-style-type: none"> <li>• Often requires a much higher copayment and/or coinsurance. See your benefit summary for costs that apply.</li> <li>• Open 24/7. Waiting periods may be longer because patients with life-threatening emergencies will be treated first.</li> </ul>



## 3 Pharmacy Facts

# Safe and easy medication management

### Getting your prescriptions



**OptumRx** is your plan's pharmacy benefits manager and works to offer safe, easy and cost-effective ways for you to get the medication you need. Show your member ID card at retail pharmacies in the U.S. to limit your out-of-pocket expenses.

OptumRx also offers the convenience of receiving prescription medications delivered to your U.S. address. You can order a three-month supply, often with a reduced copayment compared to copay at retail pharmacies. U.S. federal regulations prohibit shipment of prescription medications outside the U.S., Puerto Rico and Guam.

### What if the medication name is different?

Medication names and strengths can vary from country to country. Visit **myuhc.com** to see drug name translations and get detailed information on medications. Call **Customer Care** at for help in understanding medication differences and your benefits.

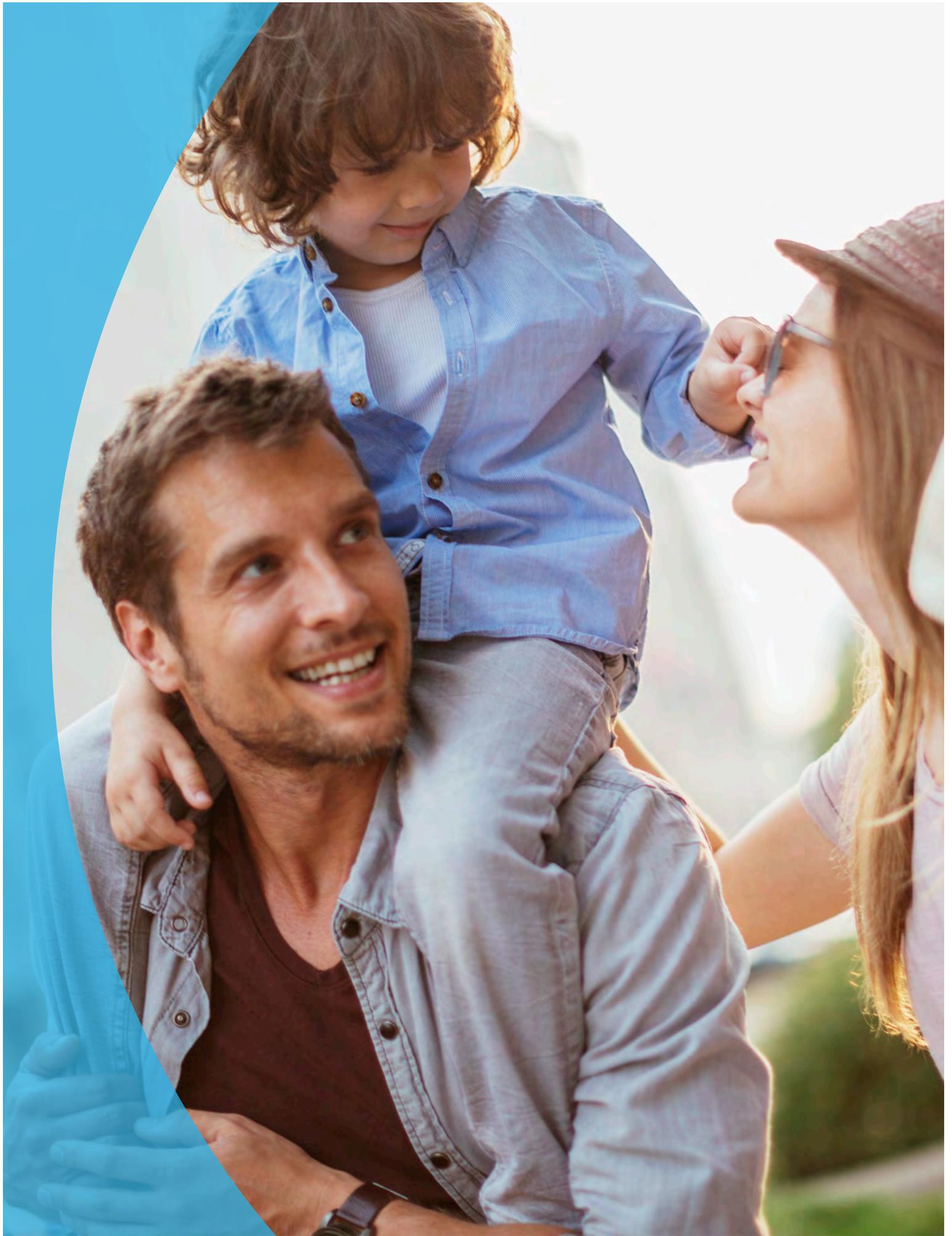
### Where to find pharmacies

In the U.S., Puerto Rico and Guam, you and covered family members can fill prescriptions at more than 67,000 in-network retail pharmacies. Locate pharmacies at **myuhc.com** or call **Customer Care** for help.

#### **A few things to note:**

- Your plan covers prescription medication only. Pharmacy benefits will not apply if your medication is available over-the-counter in the U.S.
- If you can't get a specific medication in another country, there may be a comparable option. Discuss this with your doctor ahead of time so you are prepared.

OptumRx, an affiliate of UnitedHealthcare Insurance Company, provides pharmacy benefits services. The OptumRx service mark contained in this literature are owned by UnitedHealthGroup Incorporated and its affiliated companies, many of which are registered and pending service marks in the United States and in various countries worldwide. New prescriptions should arrive within ten business days from the date the completed order is received by the Mail Service Pharmacy. Completed refill orders should arrive in about seven business days. OptumRx will contact you if there will be an extended delay in the delivery of your medications.



## 4 More Program Details

# More value, more support ... it's all part of your plan.

### Assistance services



The Customer Care Center is open around the clock to help you in an emergency. Move around the world with confidence, knowing we are here to support you.

#### Reasons to call.

Get 24/7 assistance in dealing with unforeseen medical and travel situations like:

- **Medical evacuations & repatriations**
- **Provider referral**
- **Payment coordination**
- **Device and prescription transfer**
- **Document replacement**
- **Emergency travel assistance**
- **Legal referrals**

#### Call for help:



**+1.877.844.0280** or **+1.763.274.7362** (reverse charges accepted)

# Health management and wellness services



Living and working in another country can be challenging. You may experience situations you have never had to address before. Our goal is to make sure you have the resources you need to get acclimated to your new environment and to succeed.

## Welcome call

You can schedule or request a welcome call from an experienced team member at UnitedHealthcare Global Customer Care. They will give you a short background on UnitedHealthcare and how we can help. They also will confirm or collect your email address so we can connect with you in case we need to reach you during your assignment. This is your time to share any concerns you or your family have while you are on assignment.

## Health Management Program

UnitedHealthcare Global offers the Health Management program to all covered expatriates and their families to help you access the resources you need to manage your health and chronic conditions, whether at home or on global assignment in an unfamiliar location.

The UnitedHealthcare Global Health Management program focuses on the specific needs of you and your family, wherever you are in the world. Clinicians provide targeted support and assistance and help expatriate families overcome the challenges of accessing care and resources for complex, high risk conditions. These clinicians develop a trusting relationship with program participants, getting to know their case history and needs on a personal level to help members and their families manage their health and successfully complete expatriate assignments.

The Health Management program is designed and staffed especially for expatriate populations, with focus on alleviating health-related anxieties for members and their families.

The Health Management program leverages UnitedHealthcare Global's expertise in culture, language and health care intelligence, enabling the clinicians to:

- **Identify and engage high risk individuals and families**

- **Assess the member's unique needs**
  - **Assist you in navigating complex health systems in your home and host counties**
  - **Facilitate continuity of care**
  - **Reduce the risk of complications**
  - **Promote improved clinical outcomes**

The program provides expatriate families with a clinician who will help identify solutions to alleviate medical issues, empowering you to:

- **Adapt to any changes in your clinical condition or situation**
- **Consistently stay on your medication or treatment plan**
- **Optimally manage your health**
- **Remain focused, productive and on assignment**

The UnitedHealthcare Global clinical team identifies members who may benefit from the Health Management program. Referral sources range from member self identification (i.e. pre-trip planning, continuity of care needs identification, requests for medical assistance) as well as utilization reviews by our clinical team including data indicators.

Clinicians outreach to you and begin to develop in-depth knowledge of your health issues, identify challenges and barriers to care, and develop strategies to optimize health. The cornerstone of this relationship is personal interaction and the development of an ongoing trusting relationship.

Health care professionals support participants' health needs in 5 areas of focus:

- **Medication management**
- **Durable medical equipment and supplies**
- **Dietary management**
- **Specialty providers for high impact conditions**
- **Action planning for urgent needs**

The Health Management program helps members with the following chronic conditions and more:

- **Diabetes**
- **Coronary artery disease**
- **Hypertension**
- **Back pain**
- **Asthma**

## More Program Details



- **Chronic obstructive pulmonary disease (COPD)**
- **Cancer**
- **Chronic disease**  
(i.e. Multiple Sclerosis, Parkinson's, End-Stage Renal Disease, Chron's)
- **High-risk obstetrics (OB)**
- **Premature infant**
- **Human Immunodeficiency Virus (HIV)**
- **Traumatic brain injury**
- **Stroke**
- **Renal failure/kidney disease**
- **Special needs of children**

## Behavioral Health Services

UnitedHealthcare Global is helping you take steps toward feeling healthier, happier, and more in control of your well-being with behavioral services from Optum's Live and Work Well program.

Benefits include:

- **Access to the latest news, events and library of expert articles and advice**
- **Learn about conditions and issues that may be affecting life**
- **Self-help services**
- **Interactive tools**
- **Talk to a licensed therapist or psychiatrist online**
- **Action-oriented advice**
- **Find a provider**
- **Discover local community and work-life resources**
- **Quickly and confidentially connect to expert guidance regarding conditions and situations**

Live and Work Well program is 100% digital, making it easy, convenient and safe for members to find the support they need to live their best life.

## Say goodbye to tobacco



We are committed to your wellness. If you want to kick the habit, we are here to support you. UnitedHealthcare Global covers certain over-the-counter and prescription tobacco cessation medications at \$0 cost-share, when you meet the requirements.<sup>1</sup>

### How to qualify for tobacco cessation benefits

There are just a few requirements to receive medications at \$0 cost-share. You must:

- **Be 18 or older**
- **Try an over-the-counter nicotine product** (covered only if supplied directly from the provider)
- **Get a prescription for a covered tobacco-cessation medication**
- **Fill your prescription at a network pharmacy in the U.S. or submit a claim for reimbursement if you fill your prescription at an international pharmacy.**

<p><b>Over-the counter medications</b> Covered in the U.S., prior authorization is not required. Not covered outside the U.S.</p>	<p>Nicotine replacement gum Nicotine replacement lozenge Nicotine replacement patch</p>	
<p><b>Prescription medication</b> Covered globally, prior authorization is not required.</p>	<p>Bupropion sustained-release (generic Zyban) tablet</p>	
	<p>Nicotrol Inhaler Nicotrol Nasal Spray Chantix Tablet</p>	<p>Covered after you have tried:</p> <ol style="list-style-type: none"> <li>1) One over-the-counter nicotine product (covered only when purchased at provider’s office; not covered at retail pharmacies) and</li> <li>2) Bupropion sustained-release (generic Zyban) separately</li> </ol>

<sup>1</sup> Tobacco cessation coverage at \$0 copay is available to members enrolled as part of a fully insured group. Contact UnitedHealthcare Global Customer Care to confirm program eligibility.

# Your dental benefits

## 7 key facts about your dental plan

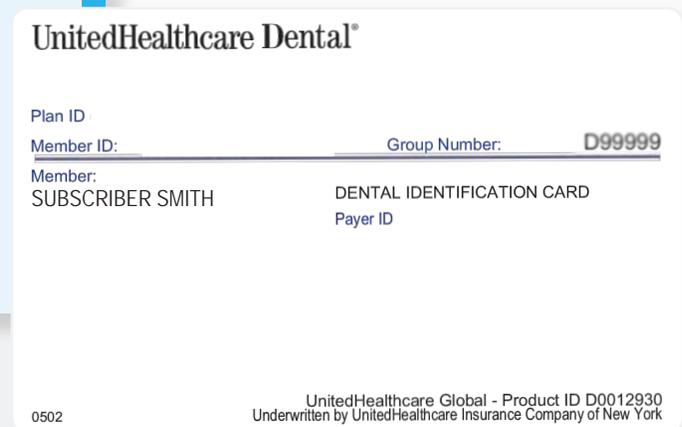


- 1 You can use the services of any dentist or dental specialist around the world. Call **Customer Care**, and we'll help you find one nearby.
- 2 In the U.S., you can save money by using a dentist or dental specialist within the UnitedHealthcare National Options PPO 30 network.
- 3 Need to see a dental specialist? You won't need a referral.
- 4 Preventive services are covered at little or no cost to you.
- 5 It's a good idea to get an estimate for dental services that may cost more than \$500. Call **Customer Care** so that we can attempt to arrange direct payment with the provider you have selected.
- 6 To find facts about your dental benefits, log in to **myuhc.com**, your member portal.
- 7 **Customer Care** is here 24/7 to offer help and answer your questions.

Taking care of your teeth and gums is important to your overall health, wherever you are in the world. Your dental benefits are designed to help you find dentists and specialists nearby so you can get the care you need.

## Your Dental ID card

- Use your dental member ID card for your dental needs.
- Bring your dental ID card with you every time you visit a dental office.
- You can always print a copy of your dental member ID card at your member portal, **myuhc.com**.



## What your dental plan covers

Preventive services are covered at little or no cost to you, as long as you use a dentist or dental specialist who is part of our network. Preventive care includes:

- **Routine exams**
- **Cleanings**
- **Oral cancer screenings for adults**
- **Sealants for children**
- **Two preventive visits in 12 consecutive months**
- **Extra visits are at no added charge for pregnant women** (ask your dentist to include the name of your obstetrician and your due date on the claim form. We'll take care of the rest).

### Other types of care

Your dental plan also covers fillings. Some plans cover only silver fillings for back teeth. If you choose white fillings, you may need to pay the difference. To see how other services are handled, log in to [myuhc.com](https://myuhc.com) and select Plan Information for details.

## Tips for choosing dental care

### Globally

You are free to seek care from dentists wherever your assignment takes you. We encourage you to call **Customer Care** for help in finding providers nearby. Our team works to set up a direct-pay arrangement with the dental office, which helps keep your expenses lower.

### In the United States

Search [myuhc.com](https://myuhc.com) for dentists who participate in the UnitedHealthcare National Options PPO 30 dental network. They have agreed to discount their services for our members by 20 to 30 percent (on average). Dentists who are not part of our network will bill you the difference between what we pay our network dentists and what your dentist typically charges.

## More Program Details

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- 2
- 3
- 4
- 5

# Preventive care services



Your benefits include preventive care services, including routine tests, pre-assignment immunizations, and screenings. Early detection enables doctors to evaluate treatment options and begin therapies that may reduce complications and the risk of disease progression. This chart displays examples of services that are typically covered. Other screenings may also be covered, up to the limit detailed on your schedule of benefits. Subject to usual & customary as well as country-appropriate guidelines. Log in to [myuhc.com](http://myuhc.com) to view your benefits limits or call **Customer Care**.

Service Category	Tests and Examinations	Service Guidelines
<b>Physical Examination</b>	Review analysis of health questionnaire Physical examination by physician Measurement of blood pressure Height and weight Rectal examination	
<b>Blood Test</b>	BUN, Creatinine T-cholesterol, Triglycerides HDL-cholesterol, LDL-cholesterol Glucose, HbA1c Na, K, Cl CBC (complete blood count) Rubella screening	Rubella screening - child-bearing years.
<b>Hepatitis Panel</b>	Hepatitis B & C	
<b>Urinalysis</b>	Ph, specific gravity, protein, ketones, nitrite glucose occult blood, bilirubin, urobilinogen	
<b>Stool Test</b>	Occult Blood in Stool	
<b>Cancer Screening</b>	Pap smear with HPV – preventive – female only	Recommend for women age 21 or older.
	Mammogram screening – female only	
	Prostate specific antigen (PSA) test – male only	Urologic Society screening recommendations for men less than age 70.
	Screening for lung cancer with low-dose computed tomography	Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
<b>Cancer Screening (Choose only one)</b>	Colonoscopy	Recommended starting at age 40-45 if high risk (a personal history of CRC or adenomatous polyp; a genetic syndrome predisposing to CRC (i.e. hereditary nonpolyposis colorectal cancer (HNPCC); familial adenomatous polyposis (FAP), one or more first-degree relatives with CRC; two or more second-degree relatives with CRC; IBD causing pancolitis or longstanding (>8 to 10 years) active disease; certain other clinical situations (such as a personal history of childhood cancer requiring abdominal radiation therapy).
	Sigmoidoscopy	Age 50-75 years, every 5 years combined with high-sensitivity fecal occult blood testing.
	Fecal Immunochemical Test	Age 50-75 years, yearly.
	Fecal DNA	Age 50-75, every 3 years.

Service Category	Tests and Examinations	Service Guidelines
<b>STD Screening</b>	Chlamydia infection screening Gonorrhea screening HIV screening Syphilis screening HPV (human papilloma virus)	
<b>Behavioral Health Screenings and Counseling</b>	Interventions to reduce alcohol misuse Chemoprevention of breast cancer (counseling) Screening for depression Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors Screening for obesity Behavioral counseling to prevent sexually transmitted infections Counseling and interventions to prevent tobacco use Behavioral counseling to prevent skin cancer Screening for intimate partner violence Counseling regarding prevention of falls in community dwelling adults 65 years or older	
<b>Immunization</b>	Routine immunizations	
<b>Other Screenings and Tests</b>	Abdominal aortic aneurysm (AAA) screening – male only	One-time screening by ultrasonography in men ages 65 to 75 years who have ever smoked.
	Osteoporosis – female only	Women 65 and over.
	Dual energy X-ray absorption for osteoporosis screening – female only	Women 65 years and older or younger women with increased fracture risk.
	Evaluation for BRCA testing and BRCA lab screening – female only	<p>Screening typically offered to women 18+ yrs. who have family members with breast, ovarian, tubal or peritoneal cancer and who have been screened with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes. Family history factors associated with increased likelihood of potentially harmful BRCA mutations include breast cancer diagnosis before age 50, bilateral breast cancer, family history of breast and ovarian cancer, presence of breast cancer in &gt; 1 male family member, multiple cases of breast cancer in the family, &gt;1 or more family members with 2 primary types of BRCA-related cancer, and Ashkenazi Jewish ancestry.</p> <p>Several familial risk stratification tools are available to determine the need for in-depth genetic counseling, such as the Ontario Family History Assessment Tool, Manchester Scoring System, Referral Screening Tool, Pedigree Assessment Tool, and FHS-7. Women with positive family history and positive screening results may receive genetic counseling and if indicated after counseling, BRCA testing. This test may NOT be given to women whose family history is not associated with an increased risk of mutation or who don't have screening associated with increased risk for BRCA mutation.</p> <p>The screening and history may need to be documented before BRCA testing would be allowed.</p>
Latent TB Screening	Latent TB Screening	Recommended for adults and children.

NOTES: Preventive services are those performed on a person who:

1. Has not had the preventive screening done before and does not have symptoms or other studies suggesting abnormalities; or
2. Has had screening done within the recommended interval with the findings considered normal; or
3. Has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals.
4. Has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy). The therapeutic service would still be considered a preventive service.

ANY of the above services MAY be appropriate if the patient has signs or symptoms of disease but then the tests are DIAGNOSTIC not PREVENTIVE and the reason for the test must be given.

5

## Reference



## What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

## What are the benefits of the Expatriate Insurance Choice Plus Plan?

### Get more protection with a national network plus international and out-of-network coverage.

This plan is designed for customers who want international coverage for employees who are living and working outside of the United States. For coverage inside the United States, a network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

- > **There's coverage internationally.** Members receive benefits for all covered services when out of the United States.
- > **There's coverage if you need to go out of the network.** U.S. Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.
- > **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.
- > **Preventive care is covered 100% International and in our U.S. network.**

**Not enrolled yet?** Learn more about this plan and search for network doctors or hospitals at [welcometouhc.com/choiceplus](http://welcometouhc.com/choiceplus) or call **1-877-844-0280**, Available 24 hours a day, 7 days a week, 365 days a year.

## Are you a member?

Easily manage your benefits online at [myuhc.com](http://myuhc.com)® and on the go with the **UnitedHealthcare Health4Me**® mobile app.

For questions, call the member phone number on your health plan ID card.

## Benefits At-A-Glance

### What you may pay for International and U.S. Network care

This chart is a simple summary of the costs you may have to pay when you receive care internationally or in the U.S. Network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
International: You have no co-payment.	International: You have no individual deductible.	International: You have no co-insurance.
U.S. Network: You have no co-payment.	U.S. Network: You have no individual deductible.	U.S. Network: You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Do not use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

## Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

### Your cost if you use International and U.S. Network Benefits

### Your cost if you use U.S. Out-of-Network Benefits

#### Annual Deductible

##### What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

##### Medical Deductible - Individual

International:  
You do not have to pay a medical deductible.  
U.S. Network:  
You do not have to pay a medical deductible.

You do not have to pay a medical deductible.

##### Medical Deductible - Family

International:  
You do not have to pay a medical deductible.  
U.S. Network:  
You do not have to pay a medical deductible.

You do not have to pay a medical deductible.

#### Out-of-Pocket Limit

##### What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> Your co-pays and co-insurance (including pharmacy) count towards meeting the out-of-pocket limit.

##### Out-of-Pocket Limit - Individual

International:  
You do not have an out-of-pocket limit.  
U.S. Network:  
You do not have an out-of-pocket limit.

\$1,000 per year

##### Out-of-Pocket Limit - Family

International:  
You do not have an out-of-pocket limit.  
U.S. Network:  
You do not have an out-of-pocket limit.

\$3,000 per year

## Your Costs

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### **What is co-insurance?**

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

### **What is a co-payment?**

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, \$50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

### **What is Prior Authorization?**

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

**International Benefits** apply to Covered Health Care Services that are received outside the United States, including United States territories.

**Network Benefits** apply to Covered Health Care Services received in the United States that are provided by a Network Physician or other Network provider.

**Out-of-Network Benefits** apply to Covered Health Care Services received in the United States that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

### **Want more information?**

Find additional definitions in the glossary at [justplainclear.com](http://justplainclear.com).

## Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Acupuncture Services</b>		
Limited to \$2,500 per year.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
<b>Ambulance Services</b>		
Emergency Ambulance:	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.
Non-Emergency Ambulance:	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply. For U.S. Network Benefits, Prior Authorization is required for Non-Emergency Ambulance.	20% co-insurance. A deductible does not apply. Prior Authorization is required for Non-Emergency Ambulance.
<b>Autism Spectrum Disorder Services</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
<b>Cellular and Gene Therapy</b>		
	The amount you pay is based on where the covered health care service is provided. For U.S. Network Benefits, Prior Authorization is required.	Prior Authorization is required.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Clinical Trials</b>		
To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Certificate of Coverage.	The amount you pay is based on where the covered health care service is provided.  For U.S. Network Benefits, Prior Authorization is required.	Prior Authorization is required.
<b>Congenital Heart Disease (CHD) Surgeries</b>		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.  Prior Authorization is required.
<b>Culturally-Based Services</b>		
Services provided outside the United States that reflect the medical standards of the country in which the service is provided, but which may otherwise be considered alternative treatments when provided within the United States as described under Culturally-Based Services in the Certificate of Coverage.	International: You pay nothing. A deductible does not apply. U.S. Network: Benefits are not available.	Benefits are not available.
<b>Dental/Anesthesia Services - Hospital Ambulatory Surgery Services</b>		
	The amount you pay is based on where the covered health care service is provided.  For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
<b>Dental Services - Accident Only</b>		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Diabetes Services</b>		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self-Management Items:	<p>International: The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Benefit.</p> <p>U.S. Network and Out-of-Network Benefits: The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider.</p>	Prior Authorization is required for DME that costs more than \$1,000.
<b>Durable Medical Equipment (DME), Orthotics and Supplies</b>		
<p>Limited to a single purchase of a type of DME or orthotic every three years. Benefits for insulin pumps are limited to one pump per year. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.</p> <p>Cochlear implants are included under Durable Medical Equipment (DME), Orthotics and Supplies as required by Wisconsin insurance law.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	20% co-insurance. A deductible does not apply.
		Prior Authorization is required for DME or orthotics that costs more than \$1,000.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Emergency Evacuation</b>		
<p>Limited to a per diem of \$300 for up to 30 days towards the living expenses incurred by the person(s) accompanying you.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: Benefits are not available.</p> <p>You must notify us as soon as the possibility of emergency evacuation arises. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.</p> <p>If you suffer a Sickness or Injury and adequate medical facilities are not available locally in the opinion of the attending Physician or our Medical Director or the Medical Director of our affiliate or authorized vendor under our discretion, we will provide emergency evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary.</p> <p>Benefits include arranging and providing for transportation and related medical services (including cost of medical escort) and medical supplies incurred in connection with the emergency evacuation. Transportation of your children (under the age of 18) either to the same location as the Covered Person or to a location where the children can be placed under the care of another guardian or relative.</p>	<p>Benefits are not available.</p>
<b>Emergency Family Reunion</b>		
<p>Limited to a per diem for living expenses for immediate family members of \$300 while the Covered Person is hospitalized up to 30 days.</p> <p>In the event that you are hospitalized for more than 7 days, or in the event of your death, Benefits are available to transport your immediate family members to join you.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p> <p>You must notify us as soon as the possibility of emergency family reunion Benefits arises. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.</p>	<p>Benefits are not available.</p>

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Emergency Health Care Services - Outpatient</b>		
International: You pay nothing. A deductible does not apply. U.S. Network: \$100 co-pay per visit. A deductible does not apply.	\$100 co-pay per visit. A deductible does not apply.	Notification is required if confined in an Out-of-Network Hospital.
<b>Gender Dysphoria</b>		
International: The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Benefit. U.S. Network and Out-of-Network Benefits: The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
<b>Habilitative Services</b>		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
		Prior Authorization is required for certain Inpatient services.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Hearing Aids</b>		
<p>Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<b>Home Health Care</b>		
<p>Limited to 120 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p> <p>To receive U.S. Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<p>Prior Authorization is required.</p>		
<b>Hospice Care</b>		
	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<p>Prior Authorization is required for Inpatient Stay.</p>		
<b>Hospital - Inpatient Stay</b>		
	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<p>Prior Authorization is required.</p>		
<b>Kidney Disease Treatment</b>		
	<p>The amount you pay is based on where the covered health care service is provided.</p>	<p>Prior Authorization is required for certain services.</p>

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Lab, X-Ray and Diagnostic - Outpatient</b>		
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
X-Ray and Other Diagnostic Testing - Outpatient:	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.		
<b>Major Diagnostic and Imaging - Outpatient</b>		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
		Prior Authorization is required.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Medical Repatriation</b>		
<p>Benefits include Repatriation of Children (under age 18) and adult family members.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p> <p>You must notify us to obtain Benefits for medical repatriation. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.</p> <p>After you receive initial treatment and stabilization for a Sickness or Injury, if the attending Physician and our Medical Director or the Medical Director of our affiliate or authorized vendor under our direction determine that it is appropriate to facilitate your recovery, we will transport you back to your permanent place of residence for further medical treatment or to recover. The timing and method of transportation will be determined solely by us and will be suitable to accommodate your medical needs. Covered Services include arranging and providing for transportation and related medical services (including medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.</p>	<p>Benefits are not available.</p>
<b>Mental Health Care and Substance - Related and Addictive Disorders Services</b>		
<p>Inpatient:</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<p>Outpatient and Transitional Care:</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<p>Partial Hospitalization/Intensive Outpatient Treatment and Transitional Care:</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
		<p>Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.</p>

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Ostomy Supplies</b>		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
<b>Outpatient Prescription Drugs</b>		
For U.S. Network and Out-of-Network Benefits are provided as described in your Outpatient Prescription Drug Rider.	International: You pay nothing. A deductible does not apply. U.S. Network: Benefits are not available.	Benefits are not available.
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications given at a doctor's office, or in a Covered Person's home.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
<b>Physician Fees for Surgical and Medical Services</b>		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Physician's Office Services - Sickness and Injury</b>		
Primary Physician Office Visit:	<p>International: You pay nothing for a primary care physician office visit. A deductible does not apply.</p> <p>U.S. Network: You pay nothing for a primary care physician office visit. A deductible does not apply.</p>	20% co-insurance. A deductible does not apply.
Specialist Physician Office Visit:	<p>International: You pay nothing for a specialist office visit. A deductible does not apply.</p> <p>U.S. Network: You pay nothing for a specialist office visit. A deductible does not apply.</p>	
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		

### Pregnancy - Maternity Services

The amount you pay is based on where the covered health care service is provided.

Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

### Preventive Care Services

Physician Office Services, Lab, X-Ray or other preventive tests.	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	20% co-insurance. A deductible does not apply.
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Certain preventive care services are provided with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Prosthetic Devices</b>		
Limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.  Prior Authorization is required for Prosthetic Devices that costs more than \$1,000.
<b>Reconstructive Procedures</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
<b>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</b>		
Limited to: 20 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implantaural therapy. 20 visits of cognitive rehabilitation therapy.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
<b>Repatriation of Remains</b>		
Benefits include Return of Children (under age 18) and adult family members. In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of your mortal remains to your permanent place of residence.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.  You must notify us to obtain Benefits for repatriation of remains. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.	Benefits are not available.

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	20% co-insurance. A deductible does not apply.
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Limited to 60 days per year in a Skilled Nursing Facility and 60 days per year in an Inpatient Rehabilitation Facility.	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p> <p>Prior Authorization is required.</p>
<b>Surgery - Outpatient</b>		
	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p> <p>Prior Authorization is required for certain services.</p>
<b>Temporomandibular Joint (TMJ) Disorder Services</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required for Inpatient Stay.
<b>Therapeutic Treatments - Outpatient</b>		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p> <p>Prior Authorization is required for certain services.</p>

## Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
<b>Transplantation Services</b>		
	<p>The amount you pay is based on where the covered health care service is provided.</p> <p>For International and U.S. Network Benefits, Prior Authorization is required.</p>	<p>Prior Authorization is required.</p>
<b>Urgent Care Center Services</b>		
<p>Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: \$50 co-pay per visit. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<b>Virtual Visits</b>		
<p>Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at <a href="http://myuhc.com">myuhc.com</a>® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<b>Vision Exams</b>		
<p>For U.S. Benefits find a listing of Spectera Eyecare Network Vision Care Providers at <a href="http://myuhcvision.com">myuhcvision.com</a>.</p> <p>Limited to 1 exam every 12 months.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>
<b>Wigs</b>		
<p>Limited to a maximum reimbursement of \$600 every 24 months.</p>	<p>International: You pay nothing. A deductible does not apply.</p> <p>U.S. Network: You pay nothing. A deductible does not apply.</p>	<p>20% co-insurance. A deductible does not apply.</p>

**Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.**

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- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

**For Internal Use only:**

**WIXABCV1966A19**

**Item#            Rev. Date**

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Expatriate Insurance/Sep/Emb/40379/2019

UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

Mail: Civil Rights Coordinator, United HealthCare Civil Rights Grievance, P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្រវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានស្តាប់អ្នក។ សមនូវសព្វទៅលើខតតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánití'go, saad bee áka'anida'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i. T'áá shqoqí ninaaltsoos nit'ízi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

# Benefit Summary

## Outpatient Prescription Drug Products

Wisconsin Plan 1973A

Standard Drugs: 10/25/60

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on [myuhc.com](http://myuhc.com)<sup>®</sup> or calling the Customer Care number on your ID card.

### Annual Drug Deductible - U.S. Network and Out-of-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

### Out-of-Pocket Drug Limit - U.S. Network

Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Out-of-Network Charges and Coupons.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

UnitedHealthcare Insurance Company

Tier Level	Up to 31-day supply	Up to 90-day supply	
	<b>Retail Network Pharmacy or Preferred Specialty Network Pharmacy</b>	<b>Retail Out-of-Network Pharmacy</b>	<b>*Mail Order Network Pharmacy**</b>
<b>Tier 1 Prescription Drug Products</b>	<b>\$10</b>	<b>\$10</b>	<b>\$25</b>
<b>Tier 2 Prescription Drug Products</b>	<b>\$25</b>	<b>\$25</b>	<b>\$62.50</b>
<b>Tier 3 Prescription Drug Products</b>	<b>\$60</b>	<b>\$60</b>	<b>\$150</b>

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

\* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com<sup>®</sup> or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

\*\* You will be charged a retail Co-payment and/or Co-insurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

For members that need to take their prescription drugs with them outside the United States, up to 365 day supply may be obtained with a prescription from a Network provider. Certain limitations may apply, such as controlled narcotics or drugs with a limited shelf-life.

## Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

Certain Preventive Care Medications may be covered. You can get more information by contacting us at [myuhc.com](http://myuhc.com)<sup>®</sup> or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy supply limits apply. Please contact us at [myuhc.com](http://myuhc.com) or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

## PHARMACY EXCLUSIONS

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The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply to U.S. Network and Out-of-Network Benefits.

### Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to Prescription Drug Products that are prescribed by a Physician for the treatment of HIV infection, illness or medical condition arising from or related to HIV infection, if the medication is approved by the FDA and prescribed and administered in accordance with the treatment protocol approved for an Investigational new drug.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for tobacco cessation.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

**WINPMCW1973A19**

**Item#      Rev. Date**

590-11184    0119\_rev02

Expatriate Rx Standard/Sep/Advantage/40380/2019

UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

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**Mail:** Civil Rights Coordinator, United HealthCare Civil Rights Grievance, P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

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**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

**請注意:** 如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

**XIN LUU Y:** Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

**알림:** 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

**PAALALA:** Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

**ВНИМАНИЕ:** бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

**تنبيه:** إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

**ATANSYON:** Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

**ATTENTION :** Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

**UWAGA:** Jeżeli mówisz po **polsku (Polish)**, udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

**ATENÇÃO:** Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

**ATTENZIONE:** in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

**ACHTUNG:** Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

**注意事項:** 日本語(**Japanese**)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

**توجه:** اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

**ध्यान दें:** यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

**CEEB TOOM:** Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

**ចំណាប់អារម្មណ៍:** បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) ស្រីវាជំនួយភាសាដើរយតតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សមន្ទវសព្វទៅលើខតតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

**PAKDAAR:** Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

**DÍI BAA'ÁKONÍNÍZIN:** **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i. T'áá shq'odi ninaaltsoos nít'izi bee nééhoziniigíí bine'déé' t'áá jíik'ehgo béésh bee hane'i biká'ígíí bee hodiilnih.

**OGOW:** Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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## Addendum to the Medical Benefit Summary

### Wisconsin–Choice Plus Expatriate Insurance

These Benefits are available to you in addition to the standard benefits presented on the Benefit Summary. The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
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#### Vision Materials

Includes Eyeglass Frames, Eyeglass Lenses and Contact Lenses.

100% of billed charges up to the maximum reimbursement.

Limited to a maximum reimbursement of \$250 every 12 months.

Benefits for these services will be paid as reimbursements. When obtaining these services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us.

If your coverage includes this benefit, the language "Glasses" listed in the exclusions section on the Benefit Summary would not apply.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

	NON-ORTHODONTICS		ORTHODONTICS	
	INTERNATIONAL/NETWORK	NON-NETWORK	INTERNATIONAL/NETWORK	NON-NETWORK
Individual Annual Calendar Year Deductible	\$0	\$0	\$0	\$0
Family Annual Calendar Year Deductible	\$0	\$0	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$2,000 per person per Calendar Year	\$2,000 per person per Calendar Year	\$2,000 per person per lifetime	
New enrollee's waiting period:	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual deductible applies to orthodontic services			No	
Orthodontic eligibility requirement			Children Only (Up to the age of 19)	
COVERED SERVICES*	INTERNATIONAL/NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
<b>DIAGNOSTIC SERVICES</b>				
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.	
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Plan Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.	
Lab and Other Diagnostic Tests	100%	100%		
<b>PREVENTIVE SERVICES</b>				
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.	
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	
Space Maintainers	100%	100%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.	
<b>BASIC SERVICES</b>				
Restorations (Amalgam or Anterior Composite)*	80%	80%	Multiple restorations on one surface will be treated as a single filling.	
Emergency Treatment / General Services	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary.	
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.	
Oral Surgery (includes surgical extractions)	80%	80%		
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement	
Endodontics	80%	80%		
<b>MAJOR SERVICES</b>				
Inlays/Onlays/Crowns*	80%	80%	Limited to 1 time per tooth per consecutive 60 months.	
Dentures and other Removable Prosthetics	80%	80%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	
Fixed Partial Dentures (Bridges)*	80%	80%	Once per tooth per consecutive 60 months.	
<b>ORTHODONTIC SERVICES</b>				
Diagnose or correct misalignment of the teeth or bite	50%	50%	Course of treatment is typically 24 months, with the initial payment at banding of 20% and remaining payment spread over the course of the treatment	

\* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

\*\*The network percentage of benefits is based on the discounted fees negotiated with the provider.

\*\*\*The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

The Prenatal Dental Care and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

# UnitedHealthcare/Dental Exclusions and Limitations

## General Limitations

**PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.

**COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to one time per consecutive 36 months. Exception to this limit will be made for Panorex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

**BITEWING RADIOGRAPHS** Limited to 1 series of films per Plan Year

**EXTRAORAL RADIOGRAPHS** Limited to 2 films per Plan Year

**DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12 months.

**FLUORIDE TREATMENTS** Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

**SEALANTS** Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

**SPACE MAINTAINERS** Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

**RESTORATIONS** Multiple restorations on 1 surface will be treated as a single filling.

**PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.

**INLAYS AND ONLAYS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

**CROWNS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

**POST AND CORES** Covered only for teeth that have had root canal therapy.

**SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

**SCALING AND ROOT PLANING** Limited to 1 time per quadrant, per consecutive 24 months.

**ROOT CANAL THERAPY** Limited to 1 time per tooth per lifetime.

**PERIODONTAL MAINTENANCE** Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

**FULL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

**PARTIAL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

**RELINING AND REBASING DENTURES** Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

**REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

**PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.

**OCCUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding.

**FULL MOUTH DEBRIDMENT** Limited to 1 time every consecutive 36 months.

**GENERAL ANESTHESIA** Covered only when clinically necessary.

**OSSEOUS GRAFTS** Limited to 1 per quadrant or site per consecutive 36 months.

**PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area

**REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

## General Exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
13. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.
14. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
15. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
16. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
17. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
18. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
19. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
20. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
21. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
22. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as an anesthesia
24. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit
25. Charges for failure to keep a scheduled appointment without giving the dental office 24-hour notice.
26. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
27. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
28. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.



# UnitedHealthcare Global Expatriate Insurance Claim Form

Return this form with a copy of the bill(s) or receipt(s) online, via mobile app, fax or mail.

Claim Type(s):  Medical  Dental  Vision  Pharmacy/Rx

## Online

www.myuhc.com

## Mobile

Download the Health4Me mobile app

## Fax

+1-877-370-4150  
+1-813-870-0796

## Mail

UnitedHealthcare Global  
PO Box 740111  
Atlanta, GA 30374-0111

### Please complete all sections of this claim form.

Claims may be delayed if all sections of this form are not completed. However, this does not guarantee that additional information will not be requested from you to process the claim. You will be notified should additional information be required.

### In order to be considered for payment:

**International:** Filing deadline is 365 days from the date of service.

**U.S.:** Please refer to your Certificate of Coverage document in www.myuhc.com. If you receive services from a U.S. in-network provider with reimbursement paid directly to the provider, filing deadline is subject to the provider's filing limit.

### Please complete a new and separate claim form for:

- Each patient
- Each currency type
- Each inpatient hospital stay
- Each different health care provider (unless multiple invoices with provider information are attached)

**Questions? Call Customer Care: +1-877-844-0280 OR +1-763-274-7362**

UnitedHealthcare Global will accept calls from a relay service for the hearing impaired.

## Section 1 – Patient Information

Member ID

Group Number

Name (Last, First, MI) \_\_\_\_\_ Date of Birth  /  /  (mm/dd/yyyy)

Gender:  Male  Female

Relationship to Subscriber/Policyholder:  Subscriber/Policyholder  Spouse/Partner  Child  Other Dependent

Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_

Street \_\_\_\_\_ Town/City \_\_\_\_\_

Region/State \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

Is the patient covered under another insurance health plan?  Yes  No If Yes: Name address and phone number of other insurance carrier:

## Section 2 – Member Reimbursement Options

(Visit [www.myuhc.com](http://www.myuhc.com) to verify and securely update your banking and currency preference.)

**Note: If no selection is made, reimbursement will be via a U.S. dollar check.**

Use previously provided banking details\*  Payment by check  Electronic funds transfer payment

One time reimbursement request (policy holder and dependents 18 years of age older)

\*Please check current payment preference on file prior to selection

Bank Name \_\_\_\_\_ Account Name/Payee \_\_\_\_\_

Bank Branch Address \_\_\_\_\_

Local ID or Passport (as applicable) \_\_\_\_\_ SWIFT/BIC Code \_\_\_\_\_ IBAN \_\_\_\_\_

Beneficiary Bank Routing/Sort Code \_\_\_\_\_ Account Number \_\_\_\_\_

Would you like to keep the banking details above on file for future reimbursements? (This option is only available to policy holders.)  Yes  No

### Section 3 – Claim Information

Provider/Facility Name \_\_\_\_\_

Provider/Facility Full Address \_\_\_\_\_

Provider Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_

Where did the treatment take place? City \_\_\_\_\_ Country \_\_\_\_\_

Type of Treatment	Diagnosis/Description of Illness or Accident	Date of Service (mm/dd/yy)	Amount Billed	Currency

Are the services provided related to an accident?  Yes  No (mm/dd/yyyy)

Type of Accident  Work  Auto  Other \_\_\_\_\_ Date of Accident  /  /

I authorize my physician to release medical information and records necessary to process this claim. (mm/dd/yyyy)

Signature \_\_\_\_\_ Date  /  /

Patient Signature (or Legal Representative)

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Member/Legal Guardian  
Signature of Minor Member or Member's Representative

Relationship to Member \_\_\_\_\_

Date  /  /  (mm/dd/yyyy)

Please maintain a copy of this document for your records.



## Contact us:

When you need help, our multilingual Customer Care Center is here to support you.



**PHONE:**

**+1.877.844.0280** or **+1.763.274.7362** (international)



**EMAIL:**

**Visit [myuhc.com](https://myuhc.com)**

Select > Expatriate Insurance > Contact Us

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03/20 MBR-C-8951

